		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0036301

Facility Name: MODERN CARE CONVALESCENT & N H

Address: 1500 WEST WALNUT (Number) JACKSONVILLE (City) 62650 (Zip Code)

County: MORGAN

Telephone Number: 217-245-4183 **Fax #** 217-243-2915

IDPA ID Number: 37-1265180

Date of Initial License for Current Owners: 07/01/90

Type of Ownership:

- [ ] VOLUNTARY,NON-PROFIT
  - [ ] Charitable Corp.
  - [ ] Trust
- [ ] PROPRIETARY
  - [ ] Individual
  - [ ] Partnership
  - [ ] Corporation
  - [X] "Sub-S" Corp.
  - [ ] Limited Liability Co.
  - [ ] Trust
  - [ ] Other
- [ ] GOVERNMENTAL
  - [ ] State
  - [ ] County
  - [ ] Other

IRS Exemption Code

In the event there are further questions about this report, please contact:
Name: Morton Doppelt, President **Telephone Number:** 217-245-4183

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) MICHAEL SCHNEIDER

(Title) ADMINISTRATOR

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) CYNTHIA S. FOOTE, PARTNER

(Firm Name & Address) ZUMBAHLEN, EYTH, SURRATT & FOOTE, LTD.
1395 LINCOLN AVENUE, JACKSONVILLE, IL 62650

(Telephone) 217-245-5121 Fax # 217-243-3356

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number MODERN CARE CONVALESCENT & N H # 0036301 Report Period Beginning: 1/1/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	68	Skilled (SNF)	68	24,820	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	68	TOTALS	68	24,820	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,069	2,034		3,103	8
9	SNF/PED					9
10	ICF	9,333	9,984	59	19,376	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,402	12,018	59	22,479	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.57%

D. How many bed-hold days during this year were paid by Public Aid?
56 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 7/1/90

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 7/1/1990 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 68 and days of care provided 1,135

Medicare Intermediary Administar Federal-Kentucky

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/2001 Fiscal Year: 12/31/2001

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number MODERN CARE CONVALESCENT & N H # 0036301 Report Period Beginning: 1/1/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	145,105	8,928	3,953	157,986	536	158,522		158,522			1
2	Food Purchase		133,968		133,968	(1,104)	132,864	(352)	132,512			2
3	Housekeeping	85,115	4,011	2,695	91,821	744	92,565		92,565			3
4	Laundry	21,173	11,933		33,106		33,106		33,106			4
5	Heat and Other Utilities			56,058	56,058	(5,878)	50,180	(2,150)	48,030			5
6	Maintenance	50,700	34,664		85,364		85,364		85,364			6
7	Other (specify):*											7
8	**TOTAL General Services**	302,093	193,504	62,706	558,303	(5,702)	552,601	(2,502)	550,099			8
	B. Health Care and Programs											
9	Medical Director					2,700	2,700		2,700			9
10	Nursing and Medical Records	821,052	80,295	803	902,150	31	902,181	(20,861)	881,320			10
10a	Therapy			47,383	47,383		47,383		47,383			10a
11	Activities	65,257	7,002		72,259	758	73,017		73,017			11
12	Social Services	41,534		5,964	47,498	(758)	46,740		46,740			12
13	Nurse Aide Training											13
14	Program Transportation			2,450	2,450	1,490	3,940	(685)	3,255			14
15	Other (specify):*			399	399	100	499	(399)	100			15
16	**TOTAL Health Care and Programs**	927,843	87,297	56,999	1,072,139	4,321	1,076,460	(21,945)	1,054,515			16
	C. General Administration											
17	Administrative	59,195			59,195		59,195		59,195			17
18	Directors Fees			67,200	67,200		67,200		67,200			18
19	Professional Services			27,051	27,051	(1,394)	25,657	(342)	25,315			19
20	Dues, Fees, Subscriptions & Promotions			28,638	28,638	(8,790)	19,848	(12,206)	7,642			20
21	Clerical & General Office Expenses	59,926	9,402		69,328	6,126	75,454		75,454			21
22	Employee Benefits & Payroll Taxes			212,935	212,935	7,024	219,959		219,959			22
23	Inservice Training & Education											23
24	Travel and Seminar					5,692	5,692		5,692			24
25	Other Admin. Staff Transportation					733	733	(266)	467			25
26	Insurance-Prop.Liab.Malpractice			38,943	38,943	50	38,993		38,993			26
27	Other (specify):*			18,898	18,898	(8,060)	10,838	(10,838)				27
28	**TOTAL General Administration**	119,121	9,402	393,665	522,188	1,381	523,569	(23,652)	499,917			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,349,057	290,203	513,370	2,152,630		2,152,630	(48,099)	2,104,531			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number MODERN CARE CONVALESCENT & N H #0036301 Report Period Beginning: 1/1/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			62,295	62,295		62,295	(8,876)	53,419			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			20,760	20,760		20,760	(10,133)	10,627			32
33	Real Estate Taxes			15,938	15,938		15,938	(3,503)	12,435			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*			8,149	8,149		8,149	(8,149)				36
37	**TOTAL Ownership**			107,142	107,142		107,142	(30,661)	76,481			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			37,230	37,230		37,230		37,230			42
43	Other (specify):* **Replacement Taxes**			3,011	3,011		3,011	(3,011)				43
44	**TOTAL Special Cost Centers**			40,241	40,241		40,241	(3,011)	37,230			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,349,057	290,203	660,753	2,300,013		2,300,013	(81,771)	2,218,242			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number MODERN CARE CONVALESCENT & N H # 0036301 Report Period Beginning: 1/1/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(2,150)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(8,876)	30		9
10	Interest and Other Investment Income	(10,133)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(8,149)	36		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(797)	27		17
18	Fines and Penalties				18
19	Entertainment	(9,748)	20		19
20	Contributions	(479)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(342)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(2,541)	27		24
25	Fund Raising, Advertising and Promotional	(2,224)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,011)	43		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(234)	20		28
29	Other-Attach Schedule	(32,118)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (80,802)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(969)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (969)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (81,771)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

MODERN CARE CONVALESCENT & N H

ID# 0036301

Report Period Beginning: 1/1/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MEDICARE DRUGS	$ (20,843)	10	1
2	APARTMENTS-RENTAL EXPENSES	(6,489)	27	2
3	APARTMENTS-REAL ESTATE TAXES	(3,503)	33	3
4	SALES TAX	(399)	15	4
5	SALES TAX	(352)	2	5
6			27	6
7	ADVERTISING	(502)	27	7
8	ENTERTAINMENT	(30)	27	8
9				9
10	ADJUSTMENTS FOR RELATED ORGANIZATIONS	(18)	10	10
11	ADJUSTMENTS FOR RELATED ORGANIZATIONS	(685)	14	11
12	ADJUSTMENTS FOR RELATED ORGANIZATIONS	(266)	25	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(33,087)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MODERN CARE CONVALESCENT & N H # 0036301 Report Period Beginning: 1/1/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(352)	0	0	0	0	0	0	0	0	0	0	(352)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(2,150)	0	0	0	0	0	0	0	0	0	0	(2,150)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,502)	0	0	0	0	0	0	0	0	0	0	(2,502)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(20,861)	0	0	0	0	0	0	0	0	0	0	(20,861)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(685)	0	0	0	0	0	0	0	0	0	0	(685)	14
15	Other (specify):*	(399)	0	0	0	0	0	0	0	0	0	0	(399)	15
16	**TOTAL Health Care and Programs**	(21,945)	0	0	0	0	0	0	0	0	0	0	(21,945)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(342)	0	0	0	0	0	0	0	0	0	0	(342)	19
20	Fees, Subscriptions & Promotions	(12,206)	0	0	0	0	0	0	0	0	0	0	(12,206)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(266)	0	0	0	0	0	0	0	0	0	0	(266)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(10,838)	0	0	0	0	0	0	0	0	0	0	(10,838)	27
28	**TOTAL General Administration**	(23,652)	0	0	0	0	0	0	0	0	0	0	(23,652)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(48,099)	0	0	0	0	0	0	0	0	0	0	(48,099)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MODERN CARE CONVALESCENT & N H # 0036301 **Report Period Beginning:** 1/1/01 **Ending:** 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(8,876)	0	0	0	0	0	0	0	0	0	0	(8,876)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(10,133)	0	0	0	0	0	0	0	0	0	0	(10,133)	32
33	Real Estate Taxes	(3,503)	0	0	0	0	0	0	0	0	0	0	(3,503)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(8,149)	0	0	0	0	0	0	0	0	0	0	(8,149)	36
37	**TOTAL Ownership**	(30,661)	0	0	0	0	0	0	0	0	0	0	(30,661)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(3,011)	0	0	0	0	0	0	0	0	0	0	(3,011)	43
44	**TOTAL Special Cost Centers**	(3,011)	0	0	0	0	0	0	0	0	0	0	(3,011)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(81,771)	0	0	0	0	0	0	0	0	0	0	(81,771)	45

Facility Name & ID Number MODERN CARE CONVALESCENT & N H # 0036301 Report Period Beginning: 1/1/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
MORTON DOPPELT	15.00			M.H. DOPPELT INC	JACKSONVILLE	CONSULTING
MARSHA DOPPELT	15.00					
STUART GREEN	20.00					
LOIS VAN BEBBER	10.00					
PAULINE PROKOP	10.00					
GERALD RAYMOND	15.00			R & D PHARMACY	JACKSONVILLE	RETAIL
SHERYL RAYMOND	15.00			R & D PHARMACY	JACKSONVILLE	RETAIL

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		STOCK CHARGES	$ 80	R & D PHARMACY	100.00%	$ 62	$ (18)	1
2	V		VAN RENTAL	1,425	R & D PHARMACY	100.00%	741	(684)	2
3	V		VAN RENTAL	555	R & D PHARMACY	100.00%	288	(267)	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 2,060			$ 1,091	$ * (969)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MODERN CARE CONVALESCENT & N H # 0036301 Report Period Beginning: 1/1/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MORTON DOPPELT	PRESIDENT	DIRECTOR	15.00		5	12.00		$		1
2	M.H. DOPPELT INC		DIRECTOR					DIRECTOR FEE	33,600	18-3	2
3											3
4	STUART GREEN	TREASURER	DIRECTOR	20.00		10	25.00	DIRECTOR FEE	16,800	18-3	4
5	PAULINE PROKOP	V PRESIDENT	DIRECTOR	10.00		1	2.00	DIRECTOR FEE	2,800	18-3	5
6	LOIS VAN BEBBER	DIRECTOR	DIRECTOR	10.00		1	2.00	DIRECTOR FEE	14,000	18-3	6
7	MARSHA DOPPELT	ADMINISTRATOR	DIRECTOR	15.00		40	100.00	SALARY	15,744	17-1	7
8	MARSHA DOPPELT	ASST ADMIN	DIRECTOR					SALARY	3,038	17-1	8
9	MARSHA DOPPELT	OFFICE CLERK	DIRECTOR					SALARY	7,499	21-1	9
10	MARSHA DOPPELT	VARIOUS	DIRECTOR					RETIREMENT	644	22-3	10
11											11
12											12
13								TOTAL	$ 94,125		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number MODERN CARE CONVALESCENT & N H # 0036301 Report Period Beginning: 1/1/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number MODERN CARE CONVALESCENT & N H # 0036301 Report Period Beginning: 1/1/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	FIRSTAR BANK		X	MORTGAGE	$10,000.00	6/2/1999	$ 400,000	$ 235,358	5/20/2003	7.7500	$ 20,760	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$10,000.00		$ 400,000	$ 235,358			$ 20,760	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 400,000	$ 235,358			$ 20,760	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number MODERN CARE CONVALESCENT & N H # 0036301 Report Period Beginning: 1/1/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 11,929	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 12,182	2
3. Under or (over) accrual (line 2 minus line 1).		$ 253	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 12,182	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 12,435	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	11,822	8
	1997	12,568	9
	1998	12,331	10
	1999	12,084	11
	2000	12,182	12

REAL ESTATE TAX ACCRUAL BASED ON PRIOR YEARS REAL ESTATE TAXES PAID

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MODERN CARE CONVALESCENT & N H COUNTY MORGAN

FACILITY IDPH LICENSE NUMBER 0036301

CONTACT PERSON REGARDING THIS REPORT MIKE SCHNEIDER

TELEPHONE 217-245-4183 FAX #: 217-243-2915

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-18-402-001	PASSAVANT PARK REAR	$ 3,628.00	$
2.	09-18-200-002	LANDS PT W 1/2 NE SEC 18	$ 12,182.00	$ 12,182.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 15,810.00	$ 12,182.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number MODERN CARE CONVALESCENT & N H # 0036301 Report Period Beginning: 1/1/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 20,069 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories ONE

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

PARC BROOKE APARTMENTS, RESIDENTIAL RENTAL; SQUARE FOOTAGE 6552 SQ. FEET

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	20,069	1990	$ 75,000	1
2					2
3	TOTALS	20,069		$ 75,000	3

Facility Name & ID Number MODERN CARE CONVALESCENT & N H # 0036301 Report Period Beginning: 1/1/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	68		1990	1961	$ 850,000	$ 26,984	31.5	$ 26,984	$	$ 310,316	4
5				1990	4,963	158	31.5	158		1,796	5
6			1990	1968	35,000	1,111	31.5	1,111		12,650	6
7											7
8											8
	Improvement Type**										
9	ADDITION OF 764 SQ FEET TO EXISTING										9
10	DINING ROOM/DAY ROOM			1997	106,549	2,732	39	2,732		12,636	10
11											11
12	SCREENED 26 X 26 FOOT GAZEBO FOR										12
13	RESIDENTS OUTSIDE ENJOYMENT			1997	25,000	1,250	20	1,250		5,573	13
14											14
15	WINDOW COVERINGS			1998	7,484		7	1,069	1,069	3,211	15
16											16
17	LAND IMPROVEMENTS-LANDSCAPING			1990	40,000		10			40,000	17
18											18
19	WATER HEATERS			1999	7,461	870	7	1,066	196	2,616	19
20											20
21	CARRIER CHILLER			1999	12,250	581	39	314	(267)	733	21
22											22
23	KITCHEN REMODELING			2000	4,428	114	39	111	(3)	203	23
24											24
25	PARKING LOT			2000	33,415	4,381	15	2,228	(2,153)	2,599	25
26											26
27	NEW SIDING			2001	14,724	330	39	346	16	346	27
28											28
29	NORTH WALL			2001	13,701	44	39	59	15	59	29
30											30
31	WINDOWS			2001	9,576	31	39	20	(11)	20	31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number MODERN CARE CONVALESCENT & N H # 0036301 Report Period Beginning: 1/1/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,164,551	$ 38,586		$ 37,448	$ (1,138)	$ 392,758	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MODERN CARE CONVALESCENT & N H # 0036301 Report Period Beginning: 1/1/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 87,322	$ 11,328	$ 15,122	$ 3,794	5-7 YRS	$ 36,836	71
72	Current Year Purchases	10,665	10,665	849	(9,816)	5-7 YRS	849	72
73	Fully Depreciated Assets	553,195					553,195	73
74								74
75	TOTALS	$ 651,182	$ 21,993	$ 15,971	$ (6,022)		$ 590,880	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	TRANSPORT RESIDENTS	FORD ECONOLINE 1996	1996	$ 37,000	$ 1,716	$	$ (1,716)	5	$ 37,000	76
77										77
78										78
79										79
80	TOTALS			$ 37,000	$ 1,716	$	$ (1,716)		$ 37,000	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,927,733	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 62,295	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 53,419	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (8,876)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,020,638	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	LAND-APARTMENTS	$ 55,000	$	$	86
87	APARTMENT BUILDING	186,500	6,782	20,063	87
88	REMODELING-APARTMENTS	5,593	203	465	88
89	EQUIPMENT-APARTMENTS	3,730	1,164	2,644	89
90					90
91	TOTALS	$ 250,823	$ 8,149	$ 23,172	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number MODERN CARE CONVALESCENT & N H # 0036301 Report Period Beginning: 1/1/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number MODERN CARE CONVALESCENT & N H # 0036301 Report Period Beginning: 1/1/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number MODERN CARE CONVALESCENT & N H # 0036301 Report Period Beginning: 1/1/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 77,724	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	230,556		3
4	Supply Inventory (priced at cost)	12,312		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	3,820		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): DUE FROM EMPLOYEES	12,552		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 336,964	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	99,659		12
13	Land	130,000		13
14	Buildings, at Historical Cost	1,356,644		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	691,912		16
17	Accumulated Depreciation (book methods)	(1,089,200)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): GOODWILL	100,000		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,289,015	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,625,979	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 38,567	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)	1,539		31
32	Accrued Real Estate Taxes(Sch.IX-B)	15,810		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	3,011		35
	Other Current Liabilities(specify):			
36	SECURITY DEPOSITS	1,075		36
37	MORTGAGE PAYABLE	105,447		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 165,449	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	129,911		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 129,911	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 295,360	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,330,619	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,625,979	$	48

*(See instructions.)

Facility Name & ID Number MODERN CARE CONVALESCENT & N H # 0036301 Report Period Beginning: 1/1/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,244,893	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,244,893	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	198,732	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(113,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **ROUNDING**	(6)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 85,726	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,330,619	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number MODERN CARE CONVALESCENT & N H # 0036301 Report Period Beginning: 1/1/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,464,202	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,464,202	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	10,133	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 10,133	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	APARTMENT RENTAL INCOME	24,410	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 24,410	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,498,745	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	555,292	31
32	Health Care	1,072,139	32
33	General Administration	525,199	33
	B. Capital Expense		
34	Ownership	107,142	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	37,230	36
	D. Other Expenses (specify):		
37	REPLACEMENT TAXES	3,011	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,300,013	40
41	**Income before Income Taxes (line 30 minus line 40)****	198,732	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 198,732	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number MODERN CARE CONVALESCENT & N H # 0036301 Report Period Beginning: 1/1/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,961	2,161	$ 50,458	$ 23.35	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,826	5,220	86,294	16.53	3
4	Licensed Practical Nurses	13,796	14,584	182,596	12.52	4
5	Nurse Aides & Orderlies	44,324	47,815	430,471	9.00	5
6	Nurse Aide Trainees	527	532	3,134	5.89	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,949	4,299	41,360	9.62	8
9	Activity Director	1,944	2,168	22,165	10.22	9
10	Activity Assistants	4,623	5,092	43,093	8.46	10
11	Social Service Workers	3,814	4,036	41,534	10.29	11
12	Dietician					12
13	Food Service Supervisor	1,920	2,468	26,067	10.56	13
14	Head Cook	2,063	2,236	19,492	8.72	14
15	Cook Helpers/Assistants	11,525	11,997	85,576	7.13	15
16	Dishwashers	1,688	1,934	14,010	7.24	16
17	Maintenance Workers	6,000	6,297	50,700	8.05	17
18	Housekeepers	10,827	11,322	85,115	7.52	18
19	Laundry	2,000	2,232	21,173	9.49	19
20	Administrator	1,840	1,880	34,837	18.53	20
21	Assistant Administrator	1,520	1,915	24,357	12.72	21
22	Other Administrative					22
23	Office Manager	2,080	2,616	47,459	18.14	23
24	Clerical	957	1,117	12,466	11.16	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,776	2,184	26,700	12.23	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	123,960	134,105	$ 1,349,057 *	$ 10.06	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	104	$ 3,953	1-3	35
36	Medical Director	8	2,700	9-6	36
37	Medical Records Consultant	32	803	10-3	37
38	Nurse Consultant	N/A			38
39	Pharmacist Consultant	96	1,200	10-6	39
40	Physical Therapy Consultant	587	34,683	10A-3	40
41	Occupational Therapy Consultant	124	8,358	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	59	4,342	10A-3	43
44	Activity Consultant	11	758	11-6	44
45	Social Service Consultant	79	5,206	12-6	45
46	Other(specify)				46
47	DENTAL CONSULTANT	6	100	15-6	47
48					48
49	TOTAL (lines 35 - 48)	1,106	$ 62,103		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number MODERN CARE CONVALESCENT & N H # 0036301 Report Period Beginning: 1/1/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MICHAEL SCHNEIDER	ADMINISTRATOR		$ 19,094
MARSHA DOPPELT	ADMINISTRATOR	15	15,744
JAMIE MARTIN	ASST ADMIN		21,319
MARSHA DOPPELT	ASST ADMIN	15	3,038
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 59,195

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
DTE TECH	Software Maint	$ 4,517
MDI	Software Consult	4,512
FR &R	Health Care Consult	1,422
Zumbahlen, Eyth, Surratt & Foote	Accounting	9,351
Thompson, Mitchell & McNeely	Legal	3,189
Rammelkamp Law Office	Legal	60
John Peterson	Medical Director	2,700
Rick Cotterman	Pharmacist Consultant	1,200
Dr Ronald Lynch	Dental Consultant	100
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 27,051

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 73,593
Unemployment Compensation Insurance	12,307
FICA Taxes	103,237
Employee Health Insurance	19,583
Employee Meals	1,104
Illinois Municipal Retirement Fund (IMRF)*	
401 (K) Employer Contributions	4,215
Employee Physicals	5,920
TOTAL (agree to Schedule V, line 22, col.8)	$ 219,959

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	2,186
Health Care Worker Background Check	384
(Indicate # of checks performed 32)	
IHCA	3,941
SUBSCRIPTIONS	931
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,642

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
ST. LOUIS MO MILEAGE	180
MDI TRAINING HOTEL ST LOUIS MO	486
In-State Travel	
MILEAGE	676
Seminar Expense	4,350
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,692

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number MODERN CARE CONVALESCENT & N H # 0036301 Report Period Beginning: 1/1/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number MODERN CARE CONVALESCENT & N H # 0036301 Report Period Beginning: 1/1/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL HEALTHCARE ASSOC.**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **NO** If YES, have these costs
been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **7 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **15,426** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen
of Public Aid during this cost report period. $ **37,230**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **YES** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed tc
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services fo
the patient census listed on page 2, Section B? **NO** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **1,104** Has any meal income been offset against
related costs? **NO** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **YES**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo
residents? **NO** If YES, please indicate the amount of income earned from such a
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **41**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all othe
times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out
out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees

Page 3, Line 27 Other

Donations	479
401 K Maintenance Fee (FFG Trust)	2,556
Non Care Related Fees	797
Advertising	502
Employee Physicals	2,965
Resident Surety Bond	50
Entertainment	30
Dues	100
Dietary Manager Dues	111
401 K Bonding	50
Rental Apartment Expenses	6,489
Bad Debts	2,541
Van Rent	1,980
Other Office Supplies	248
	18,898

Page 3 & 4 Schedule V Reclassification

Employee Benefits	5,920	
Other-General Administration		2,965
Dues Fees and Subscriptions		2,955
To reclassify employee physicals to employee benefits		
Insurance	50	
Other-General Administration		50
To reclassify resident surety bond to insurance		
Dues	100	
Other-General Administration		100
To reclassify dues related to obtaining patient supplies		
Dietary	111	
Other-General Administration		111
To reclassify dietary manager dues		
Dietary	425	
Housekeeping	744	
Nursing		1,169
To reclassify uniform costs		
Employee Benefits	1,104	
Food		1,104
To reclassifying qualifying employee meals		
Travel & Seminar	5,692	
Dues, Fees, Subscriptions, Promotions		5,692
To reclassify travel and seminar expense		
Other Administration Staff Transportation	178	
Dues & Subscription		178
To reclassify mileage to other administrative staff transportation		
Clerical & General	5,878	
Heat & Other Utilities		5,878
To reclassify telephone expense		
Medical Director	2,700	
Pharmacist Consultant- Nursing & Medical Records	1,200	
Dental Consultant-Other-Healthcare	100	
Professional Fees		4,000
To reclassify consultant services		
Program Transportation	65	
Dues, Fees, Subscriptions		65
To reclassify shuttle bus license		
Program Transportation	1,425	
Other Administration Staff Transportation	555	
Other-General Administration		1,980
To reclassify van rental used 72% for program travel and 28% for administration travel		
Clerical and Office Supplies	248	
Other-General Administrative		248
To reclassify office supplies		
Activity Consultant	758	
Social Services		758
To reclassify activity consultant		
Professional Services	2,606	
Other-General Administrative		2,606
To reclassify 401k administration fees (for employees)		

Page 19, Reconciliation of Book Income to Taxable Income

Income Per Books	$ 198,732
Rounding	(6)
Taxable Income	$ 198,726

Page 21, Part G In-State Travel

Mileage Paid To/From Seminars:

Kim Curry/Care Plan Coordinator/MDS/Care Plan/Quality Indicators/ seminar cost $200-Springfield, IL - 74 miles @.32 mile	$	23.68
Kim Curry/ADON/Wound Care/cost $150.00-Springfield, IL - 74 miles @.32 mile		23.68
Brenda Gills/RN/Pain Management-Hilton-Springfield, IL - 100 miles @ .32 mile		32.00
Kim Curry/ADON-MDS Advanced/IHCA-Signature Inn- Springfield, IL - 80 miles @ .32 mile		25.60
IHCA Annual Convention/Peoria, IL		
Peggy Cawthon/SSD - 180 miles @ .32 mile		57.60
Martha Tittsworth/PT Aide 167 miles @ .32 mile		53.44
James Sonneborn/Dietary Manager, 180 miles @ .32 mile		57.60
Carla Overton/LPN 168 miles @ .32 mile		53.76
Ernie Wright/Maintenance 194 miles @ .32		62.08
M Schneider/Administration 509 miles @ .32 mile		162.88
Boch/36 hours Activity Workshop/Springfield, IL		
Veda Baker/AD 148 miles @ .32 mile		47.36
Patsey Kelly/ADA, 75.6 miles @ .32 mile		24.19
Betty Stambaugh/ADA 70 miles @ .32 mile		22.40
Brenda Gibbs/RN/Infection Control- Convention Center- Springfield, IL - 92 miles @ .32 mile		29.44
Total	$	675.71

Page 23, Line 12

Marsha Doppelt

Administrative, Line 17	$	18,782
Office Salary, Line 21		7,499

Marsha Doppelt had salary related to administrative duties from January 2001 to August 2001. In September 2001, she became office assistant.

Page 23, Line 19 Summary of Legal Services

Workmen's Compensation Issues	$	2,907
Long Term Care Regulatory Issues		172
Unallowable Legal		170
Total	$	3,249

Page 3, Line 15

Dental Consultant	$	100
Sales Tax		399
Total		499

Page 4, Line 36

Apartment Depreciation Expense	$	8,149

Page 21, Part G. Out of State Travel

Mileage Paid To/From Out-Of-State Seminars:

Kim Curry/ADON/Allen Foods Food Show-St. Louis, MO- 175 miles @32.mile	$	56.00
Kim Curry/ADON/4th Annual World's Fair Healthcare Food Show-Hyatt Regency-St. Louis, MO - 185 miles @ .32 mile		59.20
Michael Schneider/Administration/MDI Training- St. Louis, MO 12/18 - 12/21/01 - 204 miles @ .32 mile		65.28
Total	$	180.48

Page 21, Part G
Seminar Expense: 2001

Practice Management Seminar/Changes in CPT codes St. John's H	$	109.00
Boch/Boch MDS/Care Plan/Quality indicators/Springfield, IL		200.00
Food Sanitation Course, Public Health/Jacksonville, IL		375.00
Wound Care/Springfield, IL		150.00
Allen Food/Food Show/St. Louis, MO		56.00
Nursing Pain Management (Tapes) (Could Not Attend)		54.00
Immediate Jeopardy/Healthcare Information Network/St. Louis, MO		405.00
IHCA Administrator Review Course/Springfield, IL		300.00
Pain Management/Springfield, IL		150.00
IHCA/Dietary/Nutritional Service/Springfield, IL		150.00
Employment/Labor Laws/Lorman Educational Services/Springfield, IL		199.00
4th Annual World's Fair/Healthcare Food Show/ St. Louis, MO		0.00
University of Florida/Dietary Manager Course (Independent Study Dept.)		542.00
PMAH/CPR Class/D Miller		75.00
Boch/Boch-RAI manual/Rap Modules/Psychosocial Well Being		150.00
IHCA/MDS Advanced/Springfield, IL		150.00
IDPH/Food Sanitation Course/Jacksonville, IL		75.00
IHCA/Annual Convention/Peoria, IL		495.00
PMAH Educational Service/Lower Leg Ulcers		40.00
IDPH/Food Sanitation Course/Jacksonville, IL		35.00
Boch/Boch/36 Hour Activity Workshop/Springfield, IL		555.00
IHCA/Infection Control/Convention Center/Springfield, IL		85.00
MDI Training/Schneider/St. Louis, MO		0.00
Total	$	4,350.00